



**MaineCare Services**  
An Office of the  
Department of Health and Human Services

## MDS 3.0 Training



**Case Mix Team**  
Office of MaineCare Services  
Updated May 2015

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## MDS 3.0 Training Agenda

- Welcome and overview
- History
- Chapter 2
- Case Mix Implications
- Chapter 3 – section by section
- Section S – State only
- Section X – corrections
- Questions



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## MDS 3.0 History



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### Goals of the MDS 3.0

- Resident Voice – MDS 3.0 includes interviews for Cognitive Function, Mood, Personal Preferences, and Pain.
- Clinical Relevancy – MDS 3.0 Items are based upon clinically useful and validated assessment techniques.
- Efficiency – MDS 3.0 sections are formatted to facilitate usability and minimize staff burden.

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### CMS Resources for MDS 3.0

<http://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/NursingHomeQualityInits/index.html>

**RAI Manual:** click on RAI manual on left, scroll down to bottom of page.

**Item Set** (MDS 3.0 Assessment tool): click on RAI technical information on left; scroll down to bottom of page.

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### Case Mix Implications for MDS 3.0



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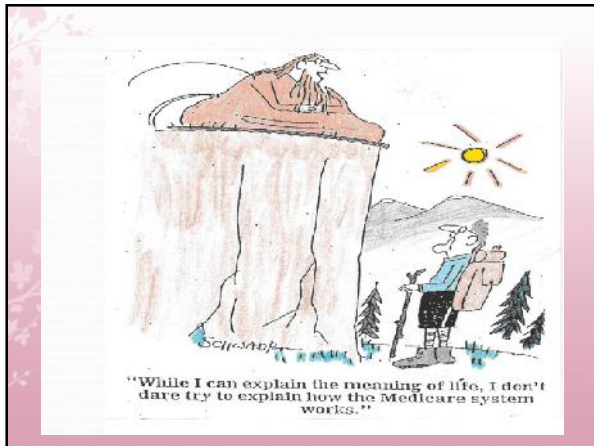
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### Case Mix Payment Items

Certain items coded as **RUG III** services, conditions, diagnoses and treatments on the MDS 3.0 assessment handout .

**RUG IV** refers to payment items for PPS services.

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### MaineCare Case Mix

Maine uses a modified RUG III Code for Case Mix purposes.

PPS / Medicare uses RUG IV codes

Supporting Documentation for Case Mix payment items is required

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## Case Mix Weights



There are 7 Categories:

- Rehabilitation
- Extensive
- Special Care
- Clinically Complex
- Impaired Cognition
- Behavior
- Reduced Physical Function
- Default or Not Classified

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Category	ADL Index	End Splits	RUG-III Codes	Main Weight
<b>Clinically Complex</b>				
Special Care qualifier (see above) and ADL score of 3 or less	1-3	Significant Depression	C22	3.0
OR	1-3	No Signs	C21	2.6
Clinically complex qualifier (any one):	4-6	Signs of Depression	C22	2.6
• Stroke (ICD-9-CM)	7-9	No Signs	C21	2.6
• Congestive Heart Failure (ICD-9-CM)	10-12	Signs of Depression	C22	2.6
• Dependence (ICD-9-CM)	13-15	No Signs	C21	2.6
• Pneumonia (ICD-9-CM)	16-18	Signs of Depression	C22	2.6
• Total Parenteral Nutrition (ICD-9-CM)	19-21	No Signs	C21	2.6
• Incontinence (ICD-9-CM)	22-24	Signs of Depression	C22	2.6
• Dehydration (ICD-9-CM)	25-27	No Signs	C21	2.6
• Feeding tube (ICD-9-CM)	28-30	Signs of Depression	C22	2.6
• Hypertension (ICD-9-CM)	31-33	No Signs	C21	2.6
• Diabetes (ICD-9-CM)	34-36	Signs of Depression	C22	2.6
• Oxygen therapy (ICD-9-CM)	37-39	No Signs	C21	2.6
• Transfusions (ICD-9-CM)	40-42	Signs of Depression	C22	2.6
• Hemodialysis (ICD-9-CM)	43-45	No Signs	C21	2.6
• Chemotherapy (ICD-9-CM)	46-48	Signs of Depression	C22	2.6
• Dialysis (ICD-9-CM)	49-51	No Signs	C21	2.6
• Physician visits (ICD-9-CM) 1+ days AND order changes (ICD-9-CM) 4+ days (at least 14 days)	52-54	Signs of Depression	C22	2.6
• Physician visits (ICD-9-CM) 2+ days AND order changes (ICD-9-CM) 4+ days (at least 14 days)	55-57	No Signs	C21	2.6
• Diabetes (ICD-9-CM) 1+ days AND order changes (ICD-9-CM) 4+ days (at least 14 days)	58-60	Signs of Depression	C22	2.6
• Diabetes (ICD-9-CM) 2+ days AND order changes (ICD-9-CM) 4+ days (at least 14 days)	61-63	No Signs	C21	2.6

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### MDS 3.0 RUG-III ADL Scoring Chart

The ADL index is used to split many of the Clinical Indicator categories. Composed from these ADL activities:

Bed Mobility = Items C01-A1 and C01-B2

Transfer = Items C01-C01 and C01-C02

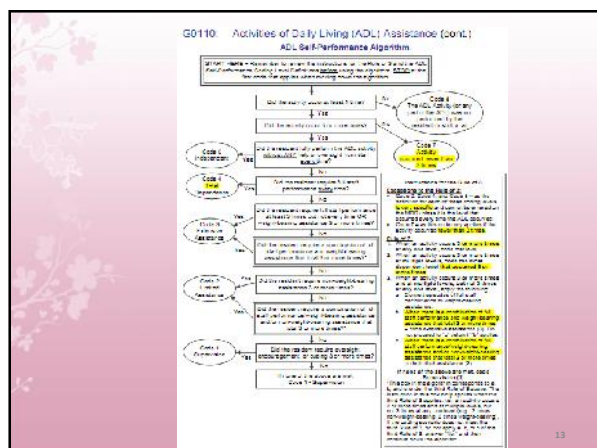
Feeding = Items C01-D01, C01-D02, C01-D03, and C01-D04

Total Use = Items C01-E1 and C01-E2

The ADL index is calculated as follows:

ADL Indicator	ADL Score
<b>Bed Mobility</b> (Total use and Transfer)	
• If the ADL indicator is 1 or 2, it is coded as the ADL score 1.	1
• If the ADL indicator is 3 or 4, it is coded as the ADL score 2.	2
• If the ADL indicator is 5 or 6, it is coded as the ADL score 3.	3
• If the ADL indicator is 7 or 8, it is coded as the ADL score 4.	4
• If the ADL indicator is 9 or 10, it is coded as the ADL score 5.	5
<b>Feeding</b>	
• If the ADL indicator is 1 or 2, it is coded as the ADL score 1.	1
• If the ADL indicator is 3 or 4, it is coded as the ADL score 2.	2
• If the ADL indicator is 5 or 6, it is coded as the ADL score 3.	3
• If the ADL indicator is 7 or 8, it is coded as the ADL score 4.	4
• If the ADL indicator is 9 or 10, it is coded as the ADL score 5.	5
<b>Transfer</b>	
• If the ADL indicator is 1 or 2, it is coded as the ADL score 1.	1
• If the ADL indicator is 3 or 4, it is coded as the ADL score 2.	2
• If the ADL indicator is 5 or 6, it is coded as the ADL score 3.	3
• If the ADL indicator is 7 or 8, it is coded as the ADL score 4.	4
• If the ADL indicator is 9 or 10, it is coded as the ADL score 5.	5

The ADL index is used to split many of the Clinical Indicator categories. Composed from these ADL activities:



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## Case Mix Quality Assurance Review

**About every 6 months, a Case Mix nurse reviews a sample of MDS 3.0 assessments and resident records to check the accuracy of the MDS 3.0 assessments.**

**Insufficient, inaccurate or lack of documentation to support information coded on the MDS 3.0 may lead to an error.**



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## Poor Documentation could also mean...



**Lower payment than the facility could be receiving, OR**

**Overpayment which could lead to re-payment to the State (Sanctions). This is due to either overstating the care a resident received or insufficient documentation to support the care that was coded.**

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## Sanctions:

2%	Error rate 34% or greater and less than 37%
5%	Error rate 37% or greater and less than 41%
7%	Error rate 41% or greater and less than 45%
10%	Error rate 45% or greater
10%	If requested reassessments not completed within 7 days

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## MaineCare Case Mix

- Resident interviews will be accepted as coded on the MDS 3.0—NO additional supporting documentation is required.
- Staff interviews **must be documented** in the resident's record. If interviews are summarized in a narrative note, the interviewer must document the **date** of the interview, **name of staff** interviewed, and staff **responses** to scripted questions asked.
- Follow all "Steps for Assessment" in the RAI Manual, for the interview items.

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## Introducing the Maine Division of Licensing and Regulatory Services (DLRS) Training Portal

Visit the portal at :  
[www.maine.gov/dhhs/dlrs/provider/mds/training/](http://www.maine.gov/dhhs/dlrs/provider/mds/training/)

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**MDS 3.0**

Long Term Care Facility  
Resident Assessment Instrument (RAI)  
User's Manual

**Chapter 2**

Effective Oct 2014

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**MDS 3.0**

Long Term Care Facility  
Resident Assessment Instrument (RAI)  
User's Manual

**Chapter 3**

Effective Oct 2014

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**Requirement for the 3.0**

- Initial and periodic assessments for **all** their residents residing in the facility for **14 or more days**.
- This includes hospice, respite, and special populations such as Pediatric and Psychiatric.

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### Responsibility of NF for Reproducing/Maintaining 3.0

Federal regulatory requirements at 42CFR483.20(d) requires NF to maintain all resident assessments completed within the previous **15 months** in the resident's active clinical record

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### Responsibilities of NF for Reproducing/Maintaining 3.0

Nursing Homes may:

1. Use electronic signatures for the MDS
2. Maintain the MDS electronically
3. Maintain the MDS and Care Plans in a separate binder in a location that is *easily and readily accessible* to staff, Surveyors, CMS etc.

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### The Alphabet Soup of MDS

OBRA = Omnibus Budget Reconciliation Act

PPS = Prospective Payment System

OMRA = Other Medicare Required Assessments (SOT, EOT, COT)

ARD = Assessment Reference Date

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**Intent:** The intent of this section is to obtain key information to uniquely identify each resident, the home in which he or she resides, and the reasons for assessment.

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- Code 1 for a **new record** that has not been previously submitted and accepted in the QIES ASAP system
- Code 2 to **modify** the MDS items for a record that has been submitted and accepted in the QIES ASAP system
- Code 3 to **inactivate** a record that already has been submitted and accepted in the QIES ASAP system

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## Section A

### A0310 Purpose

Documents the reason for completing the assessment

Identifies the required assessment content information (item set)

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## Section A

### A0310A Federal OBRA Reason for Assessment

01. Admission
02. Quarterly
03. Annual
04. Significant change in status
05. Significant correction to prior comprehensive
06. Significant correction to prior quarterly
99. Not OBRA required

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## Significant Change Criteria

- MAJOR change
- Not Self-limiting
- Impacts 2 or more areas of decline/improvement (MDS 3.0 RAI manual, pgs. 2-20 through 2-27)
- Requires IDT review and/or revision of Care Plan



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# A0310A Hospice Benefit

- Electing or revoking the hospice benefit requires a significant change in status assessment

The screenshot shows the 'A0310A. Type of Assessment' form. The 'Enter Code' field is empty. The 'Assessment' section lists four options: 01 Admission assessment (required by day 14), 02 Quarterly review assessment, 03 Annual assessment, and 04 Significant change in status assessment. The 04 option is circled in red and highlighted with a yellow box. The 05 Significant correction to prior completion assessment option is partially visible at the bottom.

A0310A. Type of Assessment	
Enter Code	A. Federal OBRA Reason for Assessment
	01 Admission assessment (required by day 14)
	02 Quarterly review assessment
	03 Annual assessment
	04 Significant change in status assessment
	05 Significant correction to prior completion assessment

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# Significant Error

**Significant Error** – is an error in an assessment where:

1. The resident's overall clinical status is not accurately represented (i.e., miscoded) on the erroneous assessment; and
2. The error has not been corrected via submission of a more recent assessment.

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[illegible]33

### Section A

#### A0310B PPS Assessment

Includes scheduled and unscheduled assessments

**PPS Assessment**

**PPS Scheduled Assessments for a Medicare Part A Stay**

01. 5-day scheduled assessment

02. 14-day scheduled assessment

03. 30-day scheduled assessment

04. 60-day scheduled assessment

05. 90-day scheduled assessment

**PPS Unscheduled Assessments for a Medicare Part A Stay**

07. Unscheduled assessment used for PPS (OMRA, significant or clinical change)

**Not PPS Assessment**

99. None of the above

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### Medicare PPS Assessments

5 day

14 day

30 day

60 day

90 day

Readmission/Return

SCSA

SCPA

Start of Therapy (SOT)

End of Therapy (EOT)

Both Start and End of Therapy

Change of Therapy (COT)

PPS Scheduled Assessments for a Medicare Part A Stay

PPS Unscheduled, OMRA used for a Medicare Part A Stay

PPS Unscheduled Assessments: Other Medicare Required Assessment (OMRA)

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### Coding Section A

#### A0310C PPS Other Medicare Required Assessment - OMRA

Indicates whether the assessment is related to therapy services

Complete this item for all assessments

0. Not an OMRA assessment

1. Start of Therapy

2. End of Therapy when ARD is 1 - 3 days after last day of therapy services

3. Start and End of Therapy

4. Change of Therapy Assessment

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Section A

A0310E Type of Assessment

Is This Assessment the First Assessment (OBRA, PPS, or Discharge) since the Most Recent Admission/Entry or Reentry?

Complete this item for all assessments

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Coding Section A

A0310F Entry/ Discharge Reporting

01. Entry tracking record  
10. Discharge assessment – return not anticipated  
11. Discharge assessment – return anticipated  
12. Death in facility tracking record  
99. None of the above

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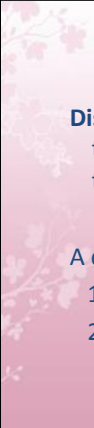
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Coding Section A

A0310G Type of Discharge

Discharge refers to the date a resident leaves the facility for anything other than a temporary LOA.

A discharge assessment is required for:

- Discharge return not anticipated
- Discharge return anticipated

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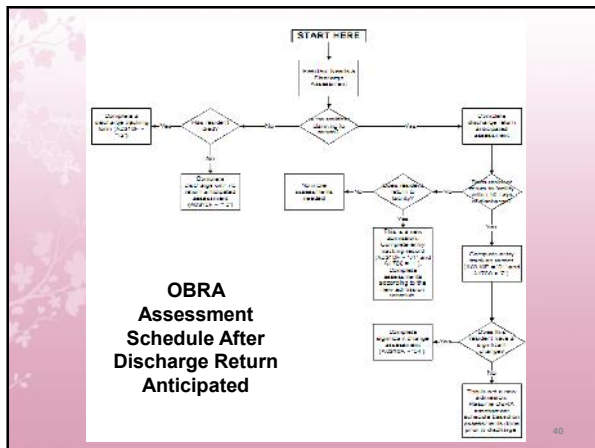
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MDS 3.0 Update for 10/1/14

**A0410. Unit Certification or Licensure Designation**

1. Unit is neither Medicare nor Medicaid certified and MDS data is not required by the State
2. Unit is neither Medicare nor Medicaid certified but MDS data is required by the State
3. Unit is Medicare and/or Medicaid certified

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**Section A Resident Data**

A0500 through A1300  
Check and double check the accuracy of the name and all numbers - social security, Medicare and MaineCare numbers, Date of Birth

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**Section A**

**A1500 PASRR/ Medicaid**

**All individuals admitted to Medicaid certified NFs must complete a Level I PASRR**

If the Level I screen is positive for known or suspected mental illness, intellectual disability, developmental disability, or “other related conditions,” a Level II evaluation is performed

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**Section A**

**A1510- Level II Preadmission Screening and Resident Review (PASRR) Conditions**

Complete only if at A0310A, Type of Assessment, you have coded

- 01 admission;
- 03 annual;
- 04 significant change; or
- 05 significant correction to prior comprehensive assessment

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**Section A**

**A1550- Level II Preadmission Screening and Resident Review (PASRR) Conditions**

**A1550. Conditions Related to ID/DD Status**  
 If the resident is 22 years of age or older, complete only if A0310A = 01.  
 If the resident is 21 years of age or younger, complete only if A0310A = 01, 03, 04, or 05.

**Check all conditions that are related to ID/DD status that were manifested before age 22, and are likely to continue indefinitely.**

<input type="checkbox"/>	<b>ID/DD With Organic Condition</b>
<input type="checkbox"/>	A. Down syndrome
<input type="checkbox"/>	B. Autism
<input type="checkbox"/>	C. Epilepsy
<input type="checkbox"/>	D. Other organic condition related to ID/DD
<input type="checkbox"/>	<b>ID/DD Without Organic Condition</b>
<input type="checkbox"/>	E. ID/DD with no organic condition
<input type="checkbox"/>	No ID/DD
<input type="checkbox"/>	Z. None of the above

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PASRR

- [http://www.qualitycareforme.com/MaineProvider\\_PASRR.htm](http://www.qualitycareforme.com/MaineProvider_PASRR.htm)

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MDS 3.0 Update for 10/1/14

A1900

A1900 Admission Date (Date this episode of care in this facility began)

MonthDayYear

Episode vs Stay

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Section A

A2300 Assessment Reference Date (ARD)

- Designates the **end** of the look-back period so that all assessment items refer to the resident's status during the same period of time.
- Anything that happens after the ARD will not be captured on that MDS.
- The look-back period includes observations and events through the end of the day (midnight) of the ARD.

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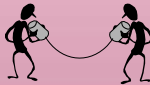
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## Section B Hearing, Speech, and Vision



**Intent:** The intent of items in this section is to document the resident's ability to hear (with assistive hearing devices, if they are used), understand, and communicate with others and whether the resident experiences visual limitations or difficulties related to diseases common in aged persons.



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## Section B

**B0100: Comatose**

B0200: Ability to Hear (with hearing aid if normally used)

B0300: Hearing Aid

B0600: Speech Clarity

**B0700: Makes Self Understood**

B0800: Ability to Understand Others

B1000: Vision (with adequate light)

B1200: Corrective Lenses

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## Section C Cognitive Patterns

**Intent: The items in this section are intended to determine the resident's attention, orientation and ability to register and recall new information. These items are crucial factors in many care-planning decisions.**



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## Section C

### C0100

Should the Brief Interview for Mental Status (BIMS) be conducted???

Code 0, no: if the interview should not be attempted because the resident is rarely/never understood, cannot respond verbally or in writing, or an interpreter is needed but not available. Skip to C0700, Staff Assessment of Mental Status.

Code 1, yes: if the interview should be attempted because the resident is at least sometimes understood verbally or in writing, and if an interpreter is needed, one is available.

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## Section C

C0600: Should the staff assessment be conducted?

**C0700-C1000 Staff assessment:**

**C0700 Short-Term Memory**

C0800 Long-Term Memory

C0900 Memory/Recall Ability

**C1000 Cognitive Skills for Daily Decision Making**

**Documentation required to confirm responses**

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## Section C

**C0200-C0500:** BIMS resident interview questions (scripted interview)



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## IMPAIRED COGNITION CATEGORY



**B0100- Comatose** (requires supporting documentation)

**AND**

C0200  
C0300  
C0400  
C0500

Resident Interview- BIMS

**OR**

B0700  
C0700  
C1000

Staff Assessment

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## Section C

C1300 Signs and Symptoms of Delirium  
C1600 Acute Onset Mental Status Change



**DEFINITIONS**

**DELIRIUM**  
A mental disturbance characterized by new or acutely worsening confusion, disordered expression of thoughts, change in level of consciousness or hallucinations.

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## Section D

### Mood

Intent: The items in this section address mood distress, a serious condition that is underdiagnosed and undertreated in the nursing home and is associated with significant morbidity. It is particularly important to identify signs and symptoms of mood distress among nursing home residents because these signs and symptoms can be treatable.



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## Section D

### D0100: Should Resident Mood Interview Be Conducted?

If yes...

**D0200** (Resident Interview – PHQ9®)

Enter the frequency of symptoms for Column 2, Items A through I

Requires no further supporting documentation.

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## Section D

### D0200

**D0200: Resident Mood Interview (PHQ-9)**

Say to resident: "Over the last 2 weeks, how you been bothered by any of the following problems?"

If symptoms present, enter "yes" in column 1, Symptom Presence.

If yes in column 1, then ask the resident "About how often have you been bothered by this?"

Read and show the resident a card with the symptom frequency choices. Indicate responses in column 2, Symptom Frequency.

1. Symptom Presence		2. Symptom Frequency	
0. No (enter 0 in column 2)	1. Yes (enter 1 in column 2)	0. Never or 1 day	1. 2-4 days (several days)
		2. 5-7 days (half or more of the days)	3. 8-14 days (nearly every day)
A. Little interest or pleasure in doing things	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
B. Feeling down, depressed, or hopeless	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
C. Trouble falling or staying asleep, or sleeping too much	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
D. Feeling tired or having little energy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
E. Poor appetite or overeating	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
F. Feeling bad about yourself – or that you are a failure or have let yourself or your family down	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
G. Trouble concentrating on things, such as reading the newspaper or watching television	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
H. Moving or speaking so slowly that other people could have noticed. Or the opposite – feeling so fidgety or restless that you have been moving around a lot more than usual	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I. Thoughts that you would be better off dead, or of hurting yourself in some way	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

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## Section D

### D0300

#### D0300 Total Severity Score

A summary of the frequency scores that indicates the extent of potential depression symptoms. The score does not diagnose a mood disorder, but provides a standard of communication with clinicians and mental health specialists.

Total score must be between 00 and 27

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## Section D D0500



Staff Assessment of Resident Mood  
*Look-back period for this item is 14 days.*

Interview staff from all shifts who know the resident best.

**Supporting documentation is required**

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D0500: Staff Assessment of Resident Mood (PHEM-017)		1. Symptoms Frequency	2. Symptoms Frequency
Based on staff's best knowledge, did the resident have any of the following symptoms or behaviors? If yes, please complete this frequency column 1 for symptoms and their associated behaviors, and indicate symptom frequency.		1. Symptoms Frequency	2. Symptoms Frequency
Enter Score in Box		Enter Score in Box	Enter Score in Box
A. Little interest or pleasure in doing things	1. The resident is always sad	<input type="checkbox"/>	<input type="checkbox"/>
B. Feeling or becoming down, depressed, or hopeless	2. Often or every day	<input type="checkbox"/>	<input type="checkbox"/>
C. Trouble falling or staying asleep, or sleeping too much	3. 1-4 days, once or twice	<input type="checkbox"/>	<input type="checkbox"/>
D. Feeling tired or having little energy	4. 5-6 days, most of the time	<input type="checkbox"/>	<input type="checkbox"/>
E. Poor appetite or over-eating	5. 7-10 days, half or more of the time	<input type="checkbox"/>	<input type="checkbox"/>
F. Feeling that the resident has about self, or others, or has felt self or family down	6. 11-12 days, nearly every day	<input type="checkbox"/>	<input type="checkbox"/>
G. Trouble concentrating on things, such as reading the newspaper or watching television		<input type="checkbox"/>	<input type="checkbox"/>
H. Moving or speaking so slowly that other people have noticed. Or the opposite - being so fidgety or restless that the resident has been noticed around after meals or at bedtime		<input type="checkbox"/>	<input type="checkbox"/>
I. Worry that the resident is doing too much or doing too little, or things are not right		<input type="checkbox"/>	<input type="checkbox"/>
J. Being short or angry, easily annoyed		<input type="checkbox"/>	<input type="checkbox"/>

D0600 = Total Severity Score (Enter score of 00 to 30)

D0650 = safety notification if there is a possibility of resident self harm

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## Section E Behavior

Intent: The items in this section identify behavioral symptoms in the last seven days that may cause distress to the resident, or may be distressing or disruptive to facility residents, staff members or the care environment.



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## BEHAVIORAL SYMPTOMS

### Payment Items



**E0100A** Hallucinations

**E0100B** Delusions

**E0200A** Physical behaviors

**E0200B** Verbal behaviors

**E0200C** Other behaviors

**E0800** Rejected care

**E0900** Wandered

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## Section E E0200

**E0200. Behavioral Symptoms - Presence & Frequency**

Behavioral symptoms and their frequency

Coding:	Enter Codes in Boxes
<input type="checkbox"/> Behavior not exhibited <input type="checkbox"/> Behavior of this type occurred 1 to 3 days <input type="checkbox"/> Behavior of this type occurred 4 to 6 days, but not daily <input type="checkbox"/> Behavior of this type occurred daily	<p><b>A. Physical behavioral symptoms directed toward others</b> (eg, hitting, kicking, pinching, scratching, grabbing, attacking, other violence)</p> <p><b>B. Verbal behavioral symptoms directed toward others</b> (eg, threatening, yelling, screaming at others, cursing, etc.)</p> <p><b>C. Other behavioral symptoms not directed toward others</b> (eg, physical symptoms such as hitting or scratching self, pacing, screaming, public sexual acts, disorderly in public, throwing or scattering food or bodily wastes, or medical/surgical symptoms (ie, screaming, blood or urine on floor))</p>

**E0300:** Overall Presence of Behavioral Symptoms  
**E0500:** Impact on Resident  
**E0600:** Impact on Others

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## Section E E0800 and E0900

**E0800: Rejection of Care – Presence & Frequency**  
**E0900: Wandering – Presence & Frequency**

**E0900. Wandering - Presence & Frequency**

Enter Code: ☐ Has the resident wandered?

0. Behavior not exhibited → Skip to E1100, Changes in Behavior or Other Symptoms

1. Behavior of this type occurred 1 to 3 days

2. Behavior of this type occurred 4 to 6 days, but less than daily

3. Behavior of this type occurred daily

**E1000:** Wandering – Impact  
     **E1000A** Risk to Self  
     **E1000B** Intrusion on others  
**E1100:** Change in Behavior or Other Symptoms

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Section F

Preferences for Customary Routine and Activities

Intent: The intent of items in this section is to obtain information regarding the resident’s preferences for his or her daily routine and activities.



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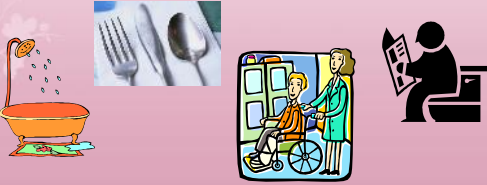
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Section G

Functional Status

Intent: Items in this section assess the need for assistance with activities of daily living (ADLs), altered gait and balance, and decreased range of motion.



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Section G


Payment Items

G0110A1, 2 Bed mobility: Self-performance & Support

G0110B1, 2 Transfer: Self-performance & Support

G0110I 1, 2 Toileting: Self-performance & Support

G0110H1 Eating: Self-performance Only



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## Section G G0110

<b>1. ADL Self-Performance</b> Code for resident's performance over all attempts, not including setup. If the ADL activity occurred 3 or more times at one level, code the most dependent concept for total dependence, which requires full staff performance every time. <b>Codings:</b> <b>Activity Occurred 3 or More Times</b> 0 Independent - no help or staff oversight at anytime 1 Supervision - requires full staff supervision at any time 2 Limited assistance - resident highly involved in activity; staff provide guided maneuvering of limbs or other non-weight bearing assistance 3 Extensive assistance - resident involved in activity; staff provide weight bearing support 4 Total dependence - full staff performance every time during entire 7 day period <b>Activity Occurred 2 or Fewer Times</b> 5 Activity occurred only once or twice - activity did occur at least once or twice 6 Activity did not occur - activity did not occur or family and/or non-facility staff provided care 100% of the time for that activity over the entire 7 day period	<b>2. ADL Support Provided</b> Code for most support provided over all attempts, including setup. If the activity occurred 3 or more times at one level, code the most dependent concept for total dependence, which requires full staff performance every time. <b>Codings:</b> 0 No setup or physical help from staff 1 Setup help only 2 One person physical assist 3 Two person physical assist 4 ADL activity itself did not occur or family and/or non-facility staff provided care 100% of the time for that activity over the entire 7 day period
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1. Self-Performance	2. Support
Enter Codes in Boxes	

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## Section G Self Performance

1. When an activity occurs 3 or more times at any one level, code that level.
2. When an activity occurs 3 or more times at multiple levels, follow the "Rule of 3" .

Exceptions to the Rule of 3:

- 0 Independent
- 4 Total Dependence
- 7 Activity occurred one or two times
- 8 Activity did not occur

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## Section G

- G0120: Bathing
  - A. Self-Performance
  - B. Support
- G0300: Balance During Transitions and Walking
- G0400: Functional Limitation in Range of Motion
  - A. Upper Extremity
  - B. Lower Extremity
- G0600: Mobility Devices (check all that apply)
- G0900: Functional Rehabilitation Potential

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## Section H Bladder and Bowel

Intent: The intent of the items in this section is to gather information on the use of bowel and bladder appliances, the use of and response to urinary toileting programs, urinary and bowel continence, bowel training programs, and bowel patterns.



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## Section H

H0100: Appliances

**H0200:** Urinary Toileting Program

A: Trial of a toileting program?

B: Response to trial

**C: Current toileting program or trial**

H0300: Urinary Continence

H0400: Bowel Continence

**H0500: Bowel Toileting Program**

H0600: Bowel Patterns



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## Scheduled Toileting/Retraining

**H0200C and H0500** are  
part of the Restorative  
Nursing Program and  
will be reviewed with  
Section O



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## Section I Active Diagnoses

Intent: The items in this section are intended to code diseases that have a *direct relationship* to the resident's current functional status, cognitive status, mood or behavior status, medical treatments, nursing monitoring, or risk of death. One of the important functions of the MDS assessment is to generate an updated, accurate picture of the resident's current health status.



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## Section I Active Diagnoses

1. Identify diagnoses in the last **60 days**
  - **physician-documented** diagnoses
2. Determine status of diagnosis
  - **7-day** look-back period,
  - Active diagnoses have a direct relationship to the resident's functional, cognitive, mood or behavior status, medical treatments or nursing monitoring
  - Only active diagnoses should be coded

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## I2300 Urinary Tract Infections

The look-back period for UTI (I2300) differs from other items

- Look-back period to determine an active diagnosis of a UTI is 30 days

Code for a UTI **only if all** of the following criteria are met:

- Diagnosis of a UTI in last 30 days
- Signs and symptoms attributed to UTI
- Positive test, study, or procedure confirming a UTI
- Medication or treatment for UTI in the last 30 days

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## DIAGNOSES (Case Mix Items)

- I2000** – Pneumonia
- I2100** - Septicemia
- I2900** - Diabetes (If N0300 = 7 and O0700 = 2 or more)
- 14300** - Aphasia (and a feeding tube)
- 14400** - Cerebral palsy
- 14900** - Hemiplegia/hemiparesis
- 15100** - Quadriplegia
- 15200** - Multiple Sclerosis
- 15500** - Traumatic brain injury (Maine only)

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## Section J



Intent: The intent of the items in this section is to document a number of health conditions that impact the resident's functional status and quality of life. The items include an assessment of pain which uses an interview with the resident or staff if the resident is unable to participate. The pain items assess the presence of pain, pain frequency, effect on function, intensity, management and control. Other items in the section assess dyspnea, tobacco use, prognosis, problem conditions, and falls.

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## Section J Pain Assessment

- J0100 Pain Management (5-day look-back)
- J0200: Should Pain Assessment Interview be Conducted?
- Pain Interview: J0300 – J0600
- J0700: Should the Staff Assessment for Pain be Conducted?
- J0800-J0850: Staff Assessment for Pain



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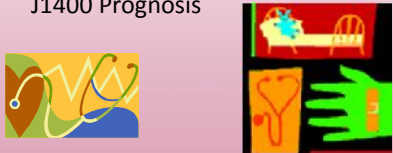
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### Section J

#### Other Health Conditions

J1100 Shortness of Breath  
J1300 Current Tobacco Use  
J1400 Prognosis



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### Section J

#### Problem Conditions

**J1550:**

- A. Fever**
- B. Vomiting**
- C. Dehydrated**
- D. Internal Bleeding**
- Z. None of the above**

Seven (7) day look-back period



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### Section J

#### Health Conditions

J1700 Fall History  
J1800 Falls since Admission/Entry  
J1900 Number of Falls since Admission



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## Section K Swallowing/Nutritional Status

Intent: The items in this section are intended to assess the many conditions that could affect the resident's ability to maintain adequate nutrition and hydration. This section covers swallowing disorders, height and weight, weight loss, and nutritional approaches. The assessor should collaborate with the dietitian and dietary staff to ensure that items in this section have been assessed and calculated accurately.



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## Section K Weight Loss/Gain

K0100: Swallowing disorder

K0200: Height and Weight

**K0300: Weight Loss**

K0310: Weight gain



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## Section K Nutritional Approaches

K0510: Approaches

**A. Parenteral / IV Feeding**

**B. Feeding Tube**

C. Mechanically Altered Diet

D. Therapeutic Diet

Z. None of the above

K0510: Nutritional Approaches		
Check all that apply. Do not check any box unless you have performed a direct observation.		
1. <b>White Soft Diet</b> The resident has had a diet of soft, moist, and tender foods that are easy to swallow and digest.	<input type="checkbox"/>	<input type="checkbox"/>
2. <b>White Soft Diet</b> The resident has had a diet of soft, moist, and tender foods that are easy to swallow and digest.	<input type="checkbox"/>	<input type="checkbox"/>
A. <b>Parenteral/IV Feeding</b> The resident has received parenteral/IV feeding.	<input type="checkbox"/>	<input type="checkbox"/>
B. <b>Feeding Tube</b> The resident has received feeding tube feeding.	<input type="checkbox"/>	<input type="checkbox"/>
C. <b>Mechanically Altered Diet</b> The resident has received a diet that has been mechanically altered.	<input type="checkbox"/>	<input type="checkbox"/>
D. <b>Therapeutic Diet</b> The resident has received a diet that has been therapeutically altered.	<input type="checkbox"/>	<input type="checkbox"/>
Z. <b>None of the above</b>	<input type="checkbox"/>	<input type="checkbox"/>

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### K0510 Assessment Guidelines



The following items are **NOT** coded in K0510A:

- ✓ IV medications
- ✓ IV fluids administered as a routine part of an operative or diagnostic procedure or recovery room stay
- ✓ IV fluids administered solely as flushes
- ✓ Parenteral/IV fluids administered in conjunction with chemotherapy or dialysis

RAI Manual pages K-10 through K-12

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### K0710A Percent Intake by Artificial Route

A. Proportion of total calories the resident received through parenteral or tube feeding

1. 25% or less
2. 26-50%
3. 51% or more

B. Average fluid intake per day by IV or tube feeding

1. 500 cc/day or less
2. 501 cc/day or more

If the resident took no food or fluids by mouth or took just sips of fluid, stop here and code 3, 51% or more.

If the resident had more substantial oral intake than this, *consult with the dietician*.

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### K0710B Average Fluid Intake per Day by IV or Tube Feeding



Code for the average number of cc per day of fluid the resident received via **IV or tube feeding**. Record what was actually received by the resident, not what was ordered.

- Code 1: 500 cc/day or less
- Code 2: 501 cc/day or more

**K0710A and B (column 3) are payment items for residents receiving nutrition via IV or Tube Feeding**

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## Section L



Intent: This item is intended to record any dental **problems** present in the 7-day look-back period.

L0200: Dental	
Check all that apply	
<input type="checkbox"/>	A. Broken or loosely fitting full or partial denture (chip, crack, cracked, undetectable or loose)
<input type="checkbox"/>	B. No natural teeth or tooth fragment(s) (edentulous)
<input type="checkbox"/>	C. Abnormal mouth tissue (ulcers, masses, oral lesions, including under denture or partial if overhanging)
<input type="checkbox"/>	D. Obvious or likely cavity or broken natural teeth
<input type="checkbox"/>	E. Inflamed or bleeding gums or loose natural teeth
<input type="checkbox"/>	F. Mouth or facial pain, discomfort or difficulty with chewing
<input type="checkbox"/>	G. Unable to examine
<input type="checkbox"/>	Z. None of the above were present

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## Section M Skin Conditions



Intent: The items in this section document the risk, presence, appearance, and change of pressure ulcers. This section also notes other skin ulcers, wounds, or lesions, and documents some treatment categories related to skin injury or avoiding injury. It is imperative to determine the etiology of all wounds and lesions, as this will determine and direct the proper treatment and management of the wound.



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## Section M

M0100: Determination of Pressure Ulcer Risk  
M0150: Risk of Pressure Ulcers  
M0210: Unhealed Pressure Ulcer(s)



**DEFINITIONS**

**PRESSURE ULCER**  
A pressure ulcer is localized injury to the skin and/or underlying tissue usually over a bony prominence, as a result of pressure, or pressure in combination with shear and/or friction.

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### Section M

#### M0300 Unhealed Pressure Ulcers

**M0300A: Number of Stage 1**  
**M0300B: Number of Stage 2**  
 number present on admission  
 date of oldest stage 2 if known  
**M0300C: Number of Stage 3**  
 number present on admission  
**M0300D: Number of Stage 4**  
 number present on admission

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### Section M

#### M0300 Unhealed Pressure Ulcers

M0300E: Unstageable Related to Non-removable dressing/device  
 number present on admission  
**M0300F: Unstageable – slough and/or eschar**  
 number present on admission  
 M0300G: Unstageable – Deep Tissue  
 number present on admission

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## PRESSURE ULCERS

### (Guidelines)

**Do not reverse stage**

- “If the pressure ulcer has ever been classified at a **deeper stage** than what is observed now, it should continue to be classified at the deeper stage”
- Determine the deepest anatomical stage of each pressure ulcer
- Enter number of pressure ulcers for each stage
- **Pressure Ulcers are Case Mix items**
  - 2+ Treatments required

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## Section M

**M0610:** Dimensions of Unhealed Stage 3 or 4 or Eschar

**M0700:** Most Severe Tissue Type for any Ulcer

**M0800:** Worsening Pressure Ulcer Status

**M0900:** Healed Pressure Ulcers

**M1030: Number of Venous and Arterial Ulcers**

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## Section M

### M1040 Other Ulcers, Wounds, and Skin Problems

M1040. Other Ulcers, Wounds and Skin Problems	
Check all that apply	
Foot Problems	
<input type="checkbox"/>	A. Infection of the foot (e.g., cellulitis, purulent drainage)
<input type="checkbox"/>	B. Diabetic foot ulcer(s)
<input type="checkbox"/>	C. Other open lesion(s) on the foot
Other Problems	
<input type="checkbox"/>	D. Open lesion(s) other than ulcers, rashes, cuts (e.g., cancer lesion)
<input type="checkbox"/>	E. Surgical wound(s)
<input type="checkbox"/>	F. Burn(s) (second or third degree)
<input type="checkbox"/>	G. Skin tear(s)
<input type="checkbox"/>	H. Moisture Associated Skin Damage (MASD) (i.e. incontinence (AD), perspiration, drainage)
None of the Above	
<input type="checkbox"/>	Z. None of the above were present

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## M1200 Skin and Ulcer Treatments

**A. Pressure reducing device for chair**

**B. Pressure reducing device for bed**

- do **not** include egg crate cushions of any type, donut or ring devices for chairs

**C. Turning/repositioning program**

- Specific approaches for changing resident's position and re-aligning the body
- Specific intervention and frequency
- Requires supporting documentation of monitoring and periodic evaluation

**D. Nutrition and hydration**

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## M1200 Skin and Ulcer Treatments



- E. Pressure Ulcer Care
- F. Surgical Wound Care
- G. Non-surgical Dressing (other than feet)  
Do NOT include Band-aids
- E. Ointments/medications (other than feet)
- F. Dressings to feet
- Z. None of the above

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## Section N Medications



Intent: The intent of the items in this section is to record the number of days, during the last 7 days (or since admission/entry or reentry if less than 7 days) that any type of injection (subcutaneous, intramuscular or intradermal), insulin, and/or select medications were received by the resident.

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## Section N INJECTIONS



### N0300

Record the number of days (during the 7-day look-back period) that the resident received **any** type of medication, antigen, vaccine, etc., by subcutaneous, intramuscular, or intradermal injection.

**Insulin injections are counted in this item as well as in Item N0350.**

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Section N  
Medications

N0350 Insulin: *Not a payment item for RUG III (MaineCare).*

A. Insulin Injections administered

B. Orders for insulin



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Section N  
Medications

N0410 Medications Received

A. Antipsychotic

B. Antianxiety

C. Antidepressant

D. Hypnotic

E. Anticoagulant

F. Antibiotic

G. Diuretic

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Section O  
Special Treatments, Procedures and Programs



Intent: The intent of the items in this section is to identify any special treatments, procedures, and programs that the resident received during the specified time periods.

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### Section O

#### Special Treatments, Procedures, and Programs

**00100. Special Treatments, Procedures, and Programs**  
 Check all of the following treatments, procedures, and programs that were performed during the last 14 days.

**1. While Not a Resident**  
 Perform while NOT a resident of this facility and within the last 14 days. Only check column 1 if services were performed on premises of the facility. If not, a resident of another facility, check column 2.

**2. While a Resident**  
 Perform while a resident of this facility and within the last 14 days.

Check all that apply

	1. While Not a Resident	2. While a Resident
<b>A. Chemotherapy</b>	<input type="checkbox"/>	<input type="checkbox"/>
<b>B. Radiation</b>	<input type="checkbox"/>	<input type="checkbox"/>
<b>C. Respiratory Treatment</b>	<input type="checkbox"/>	<input type="checkbox"/>
<b>D. Oxygen Therapy</b>	<input type="checkbox"/>	<input type="checkbox"/>
<b>E. Suctioning</b>	<input type="checkbox"/>	<input type="checkbox"/>
<b>F. Tracheostomy Care</b>	<input type="checkbox"/>	<input type="checkbox"/>
<b>G. Tracheostomy or Ventilation</b>	<input type="checkbox"/>	<input type="checkbox"/>
<b>H. BiPAP/CPAP</b>	<input type="checkbox"/>	<input type="checkbox"/>
<b>I. IV Medications</b>	<input type="checkbox"/>	<input type="checkbox"/>
<b>J. Transfusions</b>	<input type="checkbox"/>	<input type="checkbox"/>
<b>K. Dialysis</b>	<input type="checkbox"/>	<input type="checkbox"/>
<b>L. Hospice Care</b>	<input type="checkbox"/>	<input type="checkbox"/>

M. Infection or Suspected Infection (bacterial, viral, or fungal) was not treated with antibiotics, antifungals, or antivirals.

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### Section O

#### Special Treatments, Procedures, and Programs

**00250: Influenza Vaccination**  
**00300: Pneumococcal Vaccination**

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### Section O

#### Special Treatments, Procedures, and Programs

**00400A. Speech-Language Pathology and Audiology Services**  
**00400B. Occupational Therapy**  
**00400C. Physical Therapy**

**Individual minutes**

**Concurrent minutes**

**Group minutes**

**Co-treatment minutes**

**Number of Days**

**Start date**

**End date**

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## Section O

### Special Treatments, Procedures, and Programs

**00400D Respiratory Therapy**

Total minutes

**Days therapy was administered at least 15 minutes**

00400E Psychological Therapy

00400F Recreational Therapy

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## Section O

### Special Treatments, Procedures, and Programs

00420 Distinct Days of Therapy

00450 Resumption of Therapy

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## Section O

### Restorative Nursing Programs

**00500, Restorative Nursing Programs**

Record the number of days each of the following restorative programs was performed (for at least 15 minutes a day) in the last 7 calendar days (code 0 if none occurred; then 1 to number 6 or 7)

Number of Days	Technique
<input type="checkbox"/>	A. Range of motion (passive)
<input type="checkbox"/>	B. Range of motion (active)
<input type="checkbox"/>	C. Splint or brace assistance
Number of Days	Training and Skill Practice In:
<input type="checkbox"/>	D. Bed mobility
<input type="checkbox"/>	E. Transfer
<input type="checkbox"/>	F. Walking
<input type="checkbox"/>	G. Dressing and/or grooming
<input type="checkbox"/>	H. Eating and/or swallowing
<input type="checkbox"/>	I. Amputation/prosthesis care
<input type="checkbox"/>	J. Communication

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### Section O

## Restorative Nursing Programs

*Nursing interventions that promote the resident's ability to adapt and adjust to living as independently and safely as possible.*

- Measureable objectives and interventions
- Periodic evaluation by a licensed nurse
- CNAs must be trained in the techniques
- Does not require a physician's order, but a licensed nurse must supervise the activities

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### Section O

## Restorative Nursing Programs

- Nursing staff are responsible for coordination and supervision
- Does not include groups with more than 4 residents
- Code *number of days* a resident received 15 minutes or more in each category
- Remember that persons with dementia learn skills best through repetition that occurs multiple times per day.

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### Section O

## Restorative Nursing Programs

### H0200C Current toileting program

An individualized, resident-centered toileting program may decrease or prevent urinary incontinence, minimizing or avoiding the negative consequences of incontinence.

*The look-back period for this item is since the most recent admission/entry or reentry or since urinary incontinence was first noted within the facility.*

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## Section O

### Restorative Nursing Programs

H0500 Bowel Training Program

Three requirements:

- Implementation of an individualized, resident-specific bowel toileting program.
- Evidence that the program was communicated to staff and resident through care plans, flow sheets, etc.
- Documentation of the response to the toileting program and periodic evaluation

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## O0600 Physician Examination Days


### Assessment Guidelines

Over the last **14 days**, on how many **days** did the physician examine the resident?

Examinations can occur in the facility or in the physician's office.

Do **not** include:

- Examinations that occurred prior to admission/readmission to the facility
- Examinations that occurred during an ER visit or hospital observation stay



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## O0700 Physician Order Change Days

### Assessment Guidelines

Over the last **14 days**, on how many **days** did the physician change the resident's orders?

Do **not** include the following:

- Admission or re-admission orders
- Renewal of an existing order
- Clarifying orders without changes
- Orders prior to the date of admission
- Sliding scale dosage schedule
- Activation of a PRN order



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## Section P

### Restraints

Intent: The intent of this section is to record the frequency over the 7-day look-back period that the resident was restrained by any of the listed devices at any time during the day or night. Assessors will evaluate whether or not a device meets the definition of a physical restraint and code only the devices that meet the definition in the appropriate categories of Item P0100.

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## Section P

### Restraints

**P0100: Physical Restraints**

Physical restraints are any manual method or physical or mechanical device, material or agent present attached or adjacent to the resident's body that the individual cannot remove easily which restricts freedom of movement or normal access to one's body.

**Enter Codes in Boxes**

**Used in Bed**

☐ A. Bed rail

☐ B. Trunk restraint

☐ C. Limb restraint

☐ D. Other

**Used in Chair or Out of Bed**

☐ E. Trunk restraint

☐ F. Limb restraint

☐ G. Chair prevents rising

☐ H. Other

**Coding:**

0: Not used

1: Used less than daily

2: Used daily

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## Section Q

### Participation in Assessment and Goal Setting



Intent: The items in this section are intended to record the participation and expectations of the resident, family members, or significant other(s) in the assessment, and to understand the resident's overall goals. Discharge planning follow-up is already a regulatory requirement (CFR 483.20 (i)(3)). Interviewing the resident or designated individuals places the resident or their family at the center of decision-making.

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Section Q

Participation in Assessment and Goal Setting

Q0100 Participation in Assessment:  
Who participated??

Whenever possible, the resident should be actively involved-except in unusual circumstances such as if the individual is unable to understand the proceedings or is comatose.

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Section Q

Participation in Assessment and Goal Setting

Q0300 Residents Overall Expectation

- Overall expectations
- Information source

Q0400 Discharge Plan

Q0490 Preference to Avoid Being Asked

Question Q0500B

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Section Q

Participation in Assessment and Goal Setting

Q0500B Return to Community

Q0500: Return to Community

**Instructions:**

B. Ask the resident (or family or significant other or guardian or facility authorized representative if resident is unable to understand or respond): "Do you want to talk to someone about the possibility of leaving this facility and returning to live and receive services in the community?"

☐ a. No  
☐ b. Yes  
☐ c. Unknown or uncertain

The goal of follow-up action is to initiate and maintain collaboration between the nursing home and the local contact agency to support the resident's expressed interest in being transitioned to community living.

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Section Q

Participation in Assessment and Goal Setting

**Q0550A, Does the resident, (or family or significant other or guardian or legally authorized representative if resident is unable to respond) want to be asked about returning to the community on all assessments? (Rather than only on comprehensive assessments.)**

**Q0500B, what is the source of the information?**

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**Q0500B, what is the source of the information?**

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## Section Q

### Participation in Assessment and Goal Setting


## Who is the Local Contact Agency for Maine? Long Term Care Ombudsman Program

[illegible]

MDS 3.0 Update for 10/2/14

## Section 5

This section applies to the State of Maine specific data requirements.



### S0120 Residence Prior to Admission

Enter the zip code of the community address where the resident last resided prior to nursing facility admission.

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Enter the zip code of the community address where the resident last resided prior to nursing facility admission.

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MDS 3.0 Update for 10/1/14

### S0170. Advanced Directive

A. Guardian
B. Durable power of attorney for health care
C. Living will
D. Do not resuscitate
E. Do not hospitalize
F. Do not intubate
G. Feeding restrictions
H. Other treatment restrictions
Z. None of the above

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MDS 3.0 Update for 10/1/14

### S0510. PASRR Level I Screening

Was a PASRR Level I screening completed?

0. No → Skip to S3300 Weight-based Equipment Needed
1. Yes → Continue to S0511 PASRR Date
9. Unknown → Skip to S3300 Weight-based Equipment Needed

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MDS 3.0 Update for 10/1/14

### S0511. PASRR Level I Date: (Complete only if S0510 = 1)

Year				Month		Day	

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MDS 3.0 Update for 10/1/14

### S0513. PASRR Level I Screening Outcome

What was the outcome of the PASRR Level I screen?

0. Screen was sent to the NF; no diagnosis, suspected diagnosis or need for specialized services
1. Screen was sent for determination of need for Level II screen due to diagnosis, suspected diagnosis or need for specialized services related to mental illness, intellectual disability, or other related condition

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MDS 3.0 Update for 10/1/14

### S3300. Weight-based Equipment Need

Did this resident require specialized equipment based on weight since last assessment?

0. No → Skip to S6020 Specialized Needs
1. Yes → Continue to S3305 Requirements for Weight

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MDS 3.0 Update for 10/1/14

### S3305. Requirements for Care, Specifically related to Weight

- A. Lifting device. Since last assessment, was a specialized lifting device required?
- B. Wheelchair or mobility device. Since last assessment, was an oversized, non-standard wheelchair or other mobility device required?
- C. Bed. Since last assessment, was a specialized, non-standard bed required?
- D. Seating. Since last assessment, was a specialized, non-standard seat required?
- E. More than 2 staff. Since last assessment, was 3 or more staff required to provide assistance with ADL?
- Y. Other. Since last assessment, was other specialized, non-standard equipment required? \_\_\_\_\_

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MDS 3.0 Update for 10/1/14

### S6020. Specialized needs specifically related to a resident's need for a Ventilator/Respirator

A. RN expertise. Resident needs care by an RN with specialized expertise.
B. CNA training. Resident needs care by CNA staff with specialized training.
C. Therapy (PT, OT, RT) expertise. Resident needs therapy (PT, OT, RT) with specialized training or expertise.
D. Equipment. Resident needs specialized equipment.
Y. Other. Resident has other needs: <input type="text"/>
Z. None of the above

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MDS 3.0 Update for 10/1/14

### S6022. Direct care by a Licensed Nurse

A. Number of days the resident required direct care by a licensed nurse on an hourly basis. During the last 7 days or since admission/entry or reentry.
B. Number of days the resident required direct care by a licensed nurse in 15-minute intervals. During the last 7 days or since admission/entry or reentry.
C. Number of days the resident required direct care by a licensed nurse in 5-minute intervals. During the last 7 days or since admission/entry or reentry.

Enter a response for A, B, and C

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MDS 3.0 Update for 10/1/14

### S6023. Direct Care by a CNA

A. Number of days the resident required direct care by a CNA on an hourly basis. During the last 7 days or since admission/entry or reentry.
B. Number of days the resident required direct care by a CNA in 15-minute intervals. During the last 7 days or since admission/entry or reentry.
C. Number of days the resident required direct care by a CNA in 5-minute intervals. During the last 7 days or since admission/entry or reentry.



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## S6024. Direct Care by a Respiratory Therapist

- A. Number of days the resident required direct care by a licensed respiratory therapist on an hourly basis.  
During the last 7 days or since admission/entry to residency.
- B. Number of days the resident required direct care by a licensed respiratory therapist in 15-minute intervals.  
During the last 7 days or since admission/entry to residency.
- C. Number of days the resident required direct care by a licensed respiratory therapist in 5-minute intervals.  
During the last 7 days or since admission/entry to residency.



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## Resident Stays Outside of the Facility:

### S6200. Hospital Stays

### S6205. Observation Stays

### S6210. Emergency Room (ER) Visits



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## Resident Stays

**S6200. Hospital Stays** Number of hospital stays. Record number of times resident was admitted to a hospital for an overnight stay, in the last 90 days for since last assessment (if less than 90 days).

### S6205. Observation Stays

Number of observation stays. Record number of times resident had at least one overnight stay without being admitted to the hospital since the last assessment.

### S6210. Emergency Room (ER) Visits

Number of ER visits. Record number of times resident visited ER without an overnight stay, in the last 90 days (or since last assessment if less than 90 days).

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**S8010 Payment Source** – To determine payment source(s) that covers the daily per diem or ancillary services for the resident's stay in the nursing facility over the last 30 days.

- C3 – MaineCare per diem. Do not check if MaineCare is pending
- G3 MaineCare pays Medicare Co-pay

**S8099 None of the above**

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### S8510. MaineCare Therapeutic Leave Days

- A. MaineCare therapeutic leave days since last assessment. Enter the number of therapeutic leave days paid by MaineCare since the last assessment.
- B. MaineCare therapeutic leave days fiscal year-to-date. Enter the number of therapeutic leave days paid by MaineCare for State fiscal year-to-date (beginning July 1).



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**Leave of Absence, or LOA, refers to:**

- Temporary home visit
- Temporary therapeutic leave
- Hospital observation stay of less than 24h where resident is not admitted to hospital

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MDS 3.0 Update for 10/1/14

### S8512. MaineCare Hospital Bed-Hold Days

A. MaineCare hospital bed-hold days since last assessment. Enter the number of hospital bed-hold days paid by MaineCare since the last assessment.

B. MaineCare hospital bed-hold days fiscal year-to-date. Enter the number of hospital bed-hold days paid by MaineCare for State fiscal year-to-date (beginning July 1).



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### Section V Care Area Assessment Summary

CAAs

Intent: The MDS does not constitute a comprehensive assessment. Rather, it is a preliminary assessment to identify potential resident problems, strengths, and preferences.

... and CATS



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### Section V Care Area Assessment Summary

V0100 Items from Most Recent Prior OBRA or PPS Assessment

- Reason for assessment (A0310A and/or A0310B)
- Prior ARD (A2300)
- Prior BIMS score (C0500)
- Prior PHQ-9 (C0300 or C0600)

V0200: CAAs and Care Planning

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Section Z  
Assessment Administration

Intent: The intent of the items in this section is to provide billing information and signatures of persons completing the assessment.



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Section Z  
Assessment Administration

Majority of this section is completed by your software.

- Z0100 Medicare Part A Billing
- Z0150 Medicare Part A Non-Therapy
- Z0200 State Medicaid Billing
- Z0250 Alternate State Medicaid Billing
- Z0300 Insurance Billing

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Section Z  
Assessment Administration

**Z0400 Signature of Persons Completing the Assessment or Entry/Death Reporting.**

I certify that the accompanying information accurately reflects resident assessment information for this resident and that I collected or coordinated collection of this information on the dates specified. To the best of my knowledge, this information was collected in accordance with applicable Medicare and Medicaid requirements. I understand that this information is used as a basis for ensuring that residents receive appropriate and quality care, and as a basis for payment from federal funds. ***I further understand that payment of such federal funds and continued participation in the government-funded health care programs is conditioned on the accuracy and truthfulness of this information, and that I may be personally subject to or may subject my organization to substantial criminal, civil, and/or administrative penalties for submitting false information.*** I also certify that I am authorized to submit this information by this facility on its behalf.

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### Section Z

#### Assessment Administration

Z0400 Signature of Persons Completing the Assessment or Entry/Death Reporting

Z0500 Signature of RN Assessment Coordinator Verifying Assessment Completion

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### Section X

#### Correction Request

Intent: The purpose of Section X is to identify an MDS record to be modified or inactivated. Section X is only completed if Item A0050, Type of Record, is coded a 2 (**Modify** existing record) or a 3 (**Inactivate** existing record). In Section X, the facility must reproduce the information EXACTLY as it appeared on the existing erroneous record, even if the information is incorrect. This information is necessary to locate the existing record in the National MDS Database.

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### Section X

#### Correction Request

A **modification** request is used to correct a QIES ASAP record containing incorrect MDS item values due to:

- transcription errors,
- data entry errors,
- software product errors,
- item coding errors, and/or
- other error requiring modification

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## Section X Correction Request

An inactivation request is used to move an existing record in the QIES ASAP database from the active file to an archive (history file) so that it will not be used for reporting purposes.



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## Section X Correction Request: Manual Deletion



A Manual Deletion Request is required **only in the following three cases:**

1. Item A0410 Submission Requirement is incorrect.
2. Inappropriate submission of a test record as a production record.
3. Record was submitted for the wrong facility.



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## Section X Correction Request

X0150 Type of Provider  
X0200 Name of Resident  
X0300 Gender  
X0400 Date of Birth  
X0500 Social Security Number  
X0600 Type of Assessment  
X0700 Date on existing record



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Section X  
Correction Request

X0800 Correction number  
X0900 Reasons for Modification  
X1050 Reasons for Inactivation  
X1100 Name, Title, Signature, Attestation Date

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RAI Manual Chapter 5  
Submission and Correction of MDS

5.1 Transmitting MDS Data:  
The provider indicates the submission authority for a record in item A0410, Submission Requirement.

5.2 Timeliness Criteria  
5.3 Validation Edits  
5.4 Additional Medicare Submission Requirements that Impact Billing Under SNF PPS

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### Contact Information

- MDS Help Desk: 624-4019 or  
toll-free: 1-844-288-1612  
[MDS3.0.DHHS@maine.gov](mailto:MDS3.0.DHHS@maine.gov)
- Lois Bourque RN: 592-5909  
[Lois.Bourque@maine.gov](mailto:Lois.Bourque@maine.gov)
- Heidi Coombe RN: 441-6754  
[Heidi.L.Coombe@maine.gov](mailto:Heidi.L.Coombe@maine.gov)
- Darlene Scott-Rairdon RN: 215-4797  
[Darlene.Scott@maine.gov](mailto:Darlene.Scott@maine.gov)
- Maxima Corriveau RN: 215-3589  
[Maxima.Corriveau@maine.gov](mailto:Maxima.Corriveau@maine.gov)
- Sue Pinette RN: 287-3933  
[Suzanne.Pinette@maine.gov](mailto:Suzanne.Pinette@maine.gov)

[www.maine.gov/dhhs/dlrs/provider/mds/training/](http://www.maine.gov/dhhs/dlrs/provider/mds/training/)

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